Substitute per letter dated 4/7/00 w

10-010 Payment for Hospital Services

10-010.01 Approval of Payment for Hospital Inpatient Services: The Department's approval of payment for hospital inpatient services is contingent on documentation of the medical necessity for the care. Payment for hospital inpatient services will not be made if the Department's contracted Peer Review Organization (PRO) determines that the hospitalization is not medically necessary. The physician shall certify the medical necessity of the admission. The hospital shall retain the documentation in the patient's medical records for review by the Medicaid Division staff and other state and federal staff when necessary.

10-010.01A Inquiries to Providers on Claims: When the Department requests information or has questions as a result of the Department's surveillance and utilization review, the hospital shall submit all requested documentation to the Department.

10-010.02 (Reserved)

10-010.03 Payment for Hospital Inpatient Services: This subsection establishes the rate-setting methodology for hospital inpatient services used by the Nebraska Medical Assistance Program and not covered by the Nebraska Medicaid Managed Care Program's (NMMCP) capitated plans. The requirements of 42 CFR 447, Subpart C, and 42 CFR 447.205 have been met.

This subsection applies to hospital inpatient discharges occurring on or after July 25, 1995.

Payment for hospital inpatient services provided to Medicaid eligible clients is a prospective rate established by the Department for each participating hospital providing hospital inpatient services except hospitals certified as Critical Access Hospitals.

For rates effective July 25, 1995, and later, each facility shall receive a prospective rate based upon allowable operating costs and capital-related costs, and, where applicable, direct medical education costs, indirect medical education costs, and disproportionate share adjustment(s).

The Department has found and assured the Health Care Financing Administration that the rates are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities to provide services in conformance with state and federal laws, regulations, and quality and safety standards. The estimated average payment rate is expected to pay not more in the aggregate for hospital inpatient services than the amount the Department estimates would be paid for those services under the Medicare principles of reimbursement.

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All non-physician services, drugs, medical supplies, and items provided to hospital inpatients, including services and items provided under arrangements with an outside provider, must be billed as ancillary services. (See 471 NAC 10-003.05C ff. regarding the elimination of combined billing.)

10-010.03A Definitions: The following definitions apply to payment for hospital inpatient services.

Allowable Operating Costs: Those costs as provided in the Medicare statutes and regulations for cost reporting periods ending on or after January 1, 1991, and prior to January 1, 1992, for routine service costs, inpatient ancillary costs, capital-related costs, medical education costs, and malpractice insurance cost.

Base Year Cost Report: The hospital's cost report with fiscal-year-end on or after January 1, 1991, and prior to January 1, 1992, except for rebasing as noted in 471 NAC 10-010.03B9. Cost reports are reviewed using Medicare's cost reporting regulations for cost reporting periods ending on or after January 1, 1991, and prior to January 1, 1992, except for rebasing as noted in 471 NAC 10-010.03B9.

Capital-Related Costs: Those costs, excluding tax-related costs, as provided in the Medicare regulations and statutes in effect for each facility's base year.

Case-Mix Index: An arithmetical index measuring the relative average resource use of discharges treated in a hospital compared to the statewide average.

Cost Outlier: Cases which have an extraordinarily high cost as established in 471 NAC 10-010.03B5 so as to be eligible for additional payments above and beyond the initial DRG payment.

Critical Access Hospital: A hospital certified for participation in Medicare as a Critical Access Hospital.

Diagnosis-Related Group (DRG): A group of similar diagnoses combined based on patient age, procedure coding, comorbidity, and complications.

Direct Medical Education Costs Payments: An add-on to the operating cost payment amount to compensate for direct medical education costs associated with approved intern and resident programs. Costs associated with direct medical education are determined from the hospital base year cost reports, and are limited to the maximum per intern and resident amount allowed by Medicare in the base year, and are inflated to the midpoint of the rate year using the MBI.

Disproportionate Share Hospital: A hospital qualifies as a disproportionate share hospital by having -

1. a. A Medicaid inpatient utilization rate at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in Nebraska; or
   b. A low-income utilization rate of 25 percent or more; and
2. At least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are eligible for NMAP. This requirement does not apply to a hospital -
   a. The inpatients of which are predominantly individuals under 18 years of age; or
   b. Which does not offer nonemergency obstetric services to the general population as of December 21, 1987.

For a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

Distinct Part Unit: A Medicare-certified hospital-based substance abuse, psychiatric, neonatal, or physical rehabilitation unit that is certified as a distinct part unit for Medicare. Neonatal units will be recognized if they meet the criteria for a Level III neonatal intensive care unit (NICU) set forth by the American Academy of Pediatricians and American College of Obstetricians and Gynecologists in "Guidelines For Perinatal Care" Third Edition (1992). Hospitals must submit documentation to substantiate that the unit meets the criteria of a Level III NICU prior to such designation. During the initial base year, the Department will accept the Medically Handicapped Children's Program (MHCP) designation of a unit in or after 1991 as a Level III NICU as meeting this requirement.

DRG Weight: A number that reflects relative resource consumption as measured by the relative charges by hospitals for discharges associated with each DRG. That is, the Nebraska-specific DRG weight reflects the relative charge for treating discharges in all DRGs in Nebraska hospitals.

Hospital-Specific Base Year Operating Cost: Hospital specific operating cost associated with treating Medicaid patients. Operating costs include the major moveable equipment portion of capital-related costs, in accordance with appropriate Medicare regulation and exclude the building and fixtures portion of capital-related costs, direct medical education costs, and indirect medical education costs.

Indirect Medical Education Costs Payments: Payments for costs that are not directly associated with running a medical education program, but that are incurred by the facility because of that program.

Low-Income Utilization Rate: For the cost reporting period from which the prospective rate is calculated, the sum (expressed as a percentage) of the fractions, calculated from acceptable data submitted by the hospital as follows:

1. Total Medicaid inpatient revenues (excluding payments for disproportionate share hospitals) paid to the hospital, plus the amount of cash subsidies received directly from state and local governments in a cost reporting period, divided by the total amount of revenues of the hospital for inpatient services (including the amount of cash subsidies received directly from state and local governments and excluding payments for disproportionate share hospitals) in the same cost reporting period; and
2. The total amount of the hospital's charges for hospital inpatient services attributable to charity care (care provided to individuals who have no source of payment, third party, or personal resources) in a cost reporting period less the amount of any cash subsidies identified in item 1 of this definition in the cost reporting period reasonably attributable to hospital inpatient services, divided by the total amount of the hospital's charges for inpatient services in the hospital for the same period. The total inpatient charges attributed to charity care does not include contractual allowances and discounts (other than for indigent patients not eligible for Medicaid), that is, reductions in charges given to other third-party payors, such as HMO's, Medicare, or Blue Cross.

Market Basket Index (MBI): The estimate of the quarterly rate of change in the costs of goods and services that are representative of goods and services used by hospitals in the production of inpatient care, from the PPS Type Hospital Market Basket published in the DRI/McGraw Hill Health Care Costs, using the most recent historical and forecast amounts.

Medicaid Allowable Inpatient Days: The total number of covered Medicaid inpatient days.

Medicaid Inpatient Utilization Rate: The ratio of (1) covered Medicaid inpatient days, as determined by NMAP, to (2) total inpatient days, as reported by the hospital on its Medicare cost report ending in the calendar year preceding the Medicaid rate period. Inpatient days for out-of-state Medicaid patients for the same time period will be included in the computation of the ratio if reported to the Department prior to the beginning of the Medicaid rate period.

Medicaid Rate Period: The period of July 1 through the following June 30.

Medicare Cost Report: Form HCFA-2552, filed by each facility with its Medicare intermediary. The Medicare cost report which the Department shall use in the computation of the prospective rate process for any hospital which files more than one Medicare cost report for reporting periods ending during any calendar year is the one which covers -

1. At least nine months, and
2. The greatest period of time.

For any hospital which files Medicare cost reports for more than one reporting period ending during a calendar year but does not file a cost report covering a period of at least nine months, the computation rates will be based on aggregate data from all cost reports filed for reporting periods ending during that calendar year.

A hospital that does not participate in the Medicare program shall complete Form HCFA-2552 in compliance with Medicare principles and supporting rules, regulations, and statutes (i.e., the provider shall complete the Medicare cost report as though it was participating in Medicare).

The hospital shall file the completed form with the Department within five months after the end of the hospital's reporting period. A 30-day extension of the filing period may be granted if requested in writing before the end of the five-month period. Completed Forms HCFA-2552 are subject to audit by the Department or its designees (see 471 NAC 10-010.03S). Note: If a nursing facility (NF) is affiliated with the hospital, the NF cost report must be filed according to 471 NAC 12-011 ff. Note specifically that the time guidelines for filing NF cost reports differ from those for hospitals.

New Operational Facility: A facility providing inpatient hospital care which meets one of the following criteria:

1. A licensed newly constructed facility, which either totally replaces an existing facility or which is built at a site where hospital inpatient services have not previously been provided;
2. A licensed facility which begins providing hospital inpatient services in a building at a site where those services have not previously been provided; or
3. A licensed facility which is reopened at the same location where hospital inpatient care has previously been provided but not within the previous 12 months.

   Note: A new operational facility is created neither by virtue of a change in ownership nor by the construction of additional beds to an existing facility.

Operating Cost Payment Amount: The calculated payment that compensates hospitals for operating costs, including the major moveable equipment portion of capital-related costs, and excluding the building and fixtures portion of capital-related costs, direct medical education costs, and indirect medical education costs.

Peer Group: A grouping of hospitals or distinct part units with similar characteristics for the purpose of determining peer group base payment amounts. Hospitals are classified into one of six peer groups:

1. Metro Acute Care Hospitals: Hospitals with 100 or more acute care beds located in Metropolitan Statistical Area (MSAs) as designated by Medicare.
2. Other Urban Acute Hospitals: Hospitals with less than 100 acute care beds located in a Medicare-designated MSA and hospitals that have been redesignated to an MSA by Medicare;
3. Rural Acute Care Hospitals: All other acute care hospitals with 30 or more base year NMAP discharges;
4. Excluded Rural Acute Care Hospitals: Hospitals with less than 30 NMAP discharges in the base year;
5. Psychiatric Hospitals and Distinct Part Units in Acute Care Hospitals: Hospitals that are licensed as psychiatric hospitals by the licensing agency of the state in which they are located and distinct parts as defined in these regulations.
6. Rehabilitation Hospitals and Distinct Part Units: Hospitals that are licensed as rehabilitation hospitals by the licensing agency of the state in which they are located and distinct parts as defined in these regulations.
7. Critical Access Hospital: Hospitals which (1) maintain no more than 15 inpatient beds, except as permitted for CAHs having swing-bed agreements; (2) are located outside any area that is a Metropolitan Statistical Area or that is recognized as urban; and (3) are certified by HCFA as a Critical Access Hospital.

Peer Group Base Payment Amount: A base payment per discharge or per diem amount used to calculate the operating cost payment amount. The peer group base payment amount is the same for all hospitals in a peer group.

Peer Review Organization (PRO): The organization that performs medical peer review of Medicaid claims, including validation of hospital diagnosis and procedure coding information; continuation of stay, completeness, adequacy, and quality of care; appropriateness of admission, discharge and transfer; and appropriateness of prospective payment outlier cases.

Rebasing: The redetermination of the peer group base payment amount or other applicable components of the payment rates from more recent Medicaid cost report data. See 471 NAC 10-010.03B9.

Recalibration: The adjustment of all DRG weights to reflect changes in relative resource consumption and to incorporate changes necessitated by updates in the grouper used by Medicare.

Reporting Period: Each facility will be required to use the same reporting period as that used for its Medicare cost report.

Tax-Related Costs: Any real or personal property tax, sales tax, excise tax, tax enacted pursuant to the Medicaid Voluntary Contribution Provider Specific Tax Amendment of 1991 (P.L. 102-234) or any amendments thereto, franchise fee, license fee, or hospital specific tax, fee or assessment imposed by the local, state or federal government, but not including income taxes.

10.010.03B Payment for Peer Groups 1, 2, and 3 (Metro, Other Urban Acute, and Rural Acute): Payments for acute care services are made on a prospective per discharge basis except hospitals certified as Critical Access Hospitals. The total per discharge payment is the sum of -

1. The Operating Cost Payment amount;
2. The Capital-Related Cost Payment; and
3. When applicable -
   a. Direct Medical Education Cost Payment;
   b. Indirect Medical Education Cost Payment; and
   c. A Cost Outlier Payment.

10-010.03B1 Determination of Operating Cost Payment Amount: The hospital DRG operating cost payment amount is calculated for each discharge by multiplying the peer group base payment amount by the Nebraska-specific DRG relative weight. Health Care Financing Administration (HCFA) DRG definitions are adopted except for neonates.

Two sets of weights are developed for DRGs for treatment of neonates. One set of weights is developed from charges associated with treating neonates in an NICU for some portion of their hospitalization in hospitals meeting the criteria for a Level III NICU. The second set of weights is developed from charges associated with treating neonates in hospitals that do not meet Level III NICU criteria. Hospitals are reimbursed using the weight that reflects the setting for neonate treatment.

Hospitals must notify NMAP in writing within ten working days if their NICU no longer meets the criteria for a Level III NICU. Notification shall be sent to Nebraska Department of Health and Human Services Finance and Support, Hospital Program Specialist, 301 Centennial Mall South, P.O. Box 95026, Lincoln, NE 68509 or FAXed to (402) 471-9092. At the time of rebasing, each hospital with a Level III NICU must submit documentation that the unit continues to meet such Level III criteria.

10-010.03B2 Calculation of Nebraska-Specific DRG Relative Weights and Case-Mix Index: Relative weights are calculated using all applicable discharges for the period from July 1, 1990, through June 30, 1993. Statistical outliers which exceeded the average mean charges value by three standard deviations are excluded from the calculations.

Nebraska-specific weights are calculated from Medicaid charge data using the following calculations:

1. Determine the Medicaid charges for each discharge;
2. Remove all psychiatric and rehabilitation discharges;
3. Determine the arithmetic mean Medicaid charges per discharge for each DRG by dividing the sum of all Medicaid charges for each DRG by the number of discharges;
4. Determine the statewide arithmetic mean Medicaid charges per discharge by dividing the sum of all charges for all relevant discharges in the State by the number of discharges;
5. Divide the DRG arithmetic mean charges for each DRG by the statewide arithmetic mean charges to determine the Nebraska-specific relative weight for each DRG;
6. Determine proxy values for weights with insufficient sample sizes by comparing the Nebraska-specific relative weight for the DRG to the relative weights from the Kansas, Iowa, and Texas Medicaid programs, and -
   a. If the Nebraska-specific weight falls within 20% of the relative weight for that DRG for any of the selected states, the Nebraska-specific DRG will be used;
   b. If the Nebraska-specific weight does not fall within 20% of the relative weight for that DRG for any of the selected states, the average of the relative weight for that DRG for the three states will be used;
7. Adjust the relative weights so that the average of all discharges equals 1.0.

The hospital-specific case-mix index is computed based on each hospital's discharges for the period July 1, 1990, through June 30, 1991, summing the assigned DRG relative weights and dividing by the total number of Medicaid discharges.

10-010.03B2a Recalibrating Relative Weights: DRG relative weights will be recalibrated each year, prior to the start of each Medicaid rate period. Recalibration will adjust each relative weight proportionally so that the projected average of all discharges equals 1.0.

10-010.03B3 Calculation of Case-Mix Adjusted Hospital-Specific Base Year Operating Cost Per Discharge: Medicaid case-mix adjusted hospital-specific base year operating costs per discharge amounts are calculated from base year Medicare cost reports as follows:

1. Routine service costs - Medicaid routine service costs are calculated by allocating total hospital routine service costs for each applicable routine service cost center based on the percentage of Medicaid patient days to total patient days. Amounts are net of swing-bed costs and observation bed costs.
2. Inpatient ancillary service costs - Medicaid inpatient ancillary service costs are calculated by multiplying an overall ancillary cost-to-charge ratio times the applicable Medicaid program inpatient ancillary charges. The overall ancillary cost-to-charge ratio is calculated by dividing the sum of the costs of all ancillary and outpatient service cost centers by the sum of the charges for all ancillary and outpatient service cost centers.
3. Total hospital-specific base year operating costs amounts are equal to the sum of Medicaid routine service costs and Medicaid inpatient ancillary service costs, less the building and fixtures portion of capital-related costs as determined in 471 NAC 10-010.03B7.
4. Hospital-specific base year operating costs are divided by the hospital's base year case-mix index and the number of base year Medicaid discharges, and if applicable, the hospital's indirect medical education factor.

10-010.03B4 Calculation of Peer Group Base Payment Amount: Peer group base payment amounts are calculated as a percentage of the weighted median of case mix adjusted hospital-specific base year operating costs per discharge, inflated to the midpoint of the rate year using the MBI. The peer group case-weighted median is determined. The case-weighted median is multiplied by a percentage:

1. For metro acute care hospitals, the percentage is 85%;
2. For other urban acute care hospitals, the percentage is 100%;
3. For rural acute care hospitals, the percentage is 100%.

10-010.03B4a Consideration for Hospitals that Primarily Serve Children: Effective January 1, 1997, a hospital qualifies for this group when it is located in Nebraska and is certified as meeting the criteria, as a children's hospital, for exclusion from the Medicare Prospective Payment System (PPS). The Department will make operating cost payments calculated at 120% of the peer group base payment amount for peer group 1 (Metro Acute Hospitals).

10-010.03B5 Calculation of Cost Outlier Payment Amounts: Additional payment is made for approved discharges meeting or exceeding Medicaid criteria for cost outliers for each DRG. Cost outliers may be subject to PRO review.

Discharges qualify as cost outliers when the costs of the service exceed the outlier threshold. The outlier threshold is the sum of the operating cost payment amount and the capital-related cost payment amount, plus $20,500. Cost of the discharge is calculated by multiplying the hospital-specific cost-to-charge ratio determined from the base year cost report times the allowed charges. Additional payment for cost outliers is 60% of the difference between the hospital's cost for the discharge and the outlier threshold for all discharges except for burn discharges, which will be paid at 67.5%.

10-010.03B6 Medical Education Costs

10-010.03B6a Calculation of Direct Medical Education Cost Payments: Hospital-specific direct medical education costs reflect the Nebraska Medical Assistance Program's average cost per discharge for approved intern and resident programs. Amounts are subject to the maximum per intern and resident amount allowed by Medicare in the base year, adjusted to reflect the changes in the number of interns and residents reported in the most recent Medicare cost report filed with the Department, and adjusted for inflation using the MBI. To determine the direct medical education payment amount for each discharge, adjusted amounts are allocated to the Medicaid program based on the percentage of Medicaid patient days to total patient days in the base-year, and are divided by the number of base year Medicaid discharges and multiplied by 75%.

NMAP will calculate a quarterly Direct Medical Education payment for services provided by NMMCP capitated plans from discharge data provided by the plan(s). Payment will be the number of discharges times the direct medical education cost payment as calculated in this section.

10-010.03B6b Calculation of Indirect Medical Education (IME) Cost Payments: Hospitals qualify for IME payments when they receive a direct medical education payment from NMAP, and qualify for indirect medical education payments from Medicare. Recognition of indirect medical education costs incurred by hospitals are an add-on calculated by multiplying an IME factor by the sum of the operating cost payment amount and the outlier payment amount times 75%.